



4-1-2004

The Implications of Using the Medical Expense Deduction of I.R.C. 213 to Subsidize Assisted Reproductive Technology

Anna L. Benjamin

Follow this and additional works at: <http://scholarship.law.nd.edu/ndlr>

Recommended Citation

Anna L. Benjamin, *The Implications of Using the Medical Expense Deduction of I.R.C. 213 to Subsidize Assisted Reproductive Technology*, 79 Notre Dame L. Rev. 1117 (2004).

Available at: <http://scholarship.law.nd.edu/ndlr/vol79/iss3/5>

This Note is brought to you for free and open access by NDLScholarship. It has been accepted for inclusion in Notre Dame Law Review by an authorized administrator of NDLScholarship. For more information, please contact lawdr@nd.edu.

THE IMPLICATIONS OF USING THE MEDICAL EXPENSE DEDUCTION OF I.R.C. § 213 TO SUBSIDIZE ASSISTED REPRODUCTIVE TECHNOLOGY

*Anna L. Benjamin**

INTRODUCTION

For millions of people, the dream of becoming a parent represents life's ultimate goal. Some couples achieve this dream through little more than good timing or even a happy accident. But, for a growing number of men and women, conceiving a child remains an elusive ambition.¹ Infertility is as old as the Bible,² yet modern medicine provides options for infertile couples that would astound past generations.³ Science can now combine sperm and egg to begin life in a laboratory,⁴ and many couples choose to endure every medical possibility for the chance to create a new life.

* Candidate for Juris Doctor, Notre Dame Law School, 2004; B.A., Government and International Studies, Sociology, University of Notre Dame, 2001. I would like to thank Professor Michael Kirsch for his invaluable comments and suggestions, and the members of the *Notre Dame Law Review* for their hard work and attention to detail. This Note is dedicated to my parents, Ronald and Patricia, for their unconditional love and encouragement, and for teaching me by example that with perseverance and faith, all things are possible.

1 See James B. Roche, *After Bragdon v. Abbot: Why Legislation is Still Needed to Mandate Infertility Insurance*, 11 B.U. PUB. INT. L.J. 215, 215 (2002); Thomas D. Flanigan, Note, *Assisted Reproductive Technologies and Insurance Under the Americans with Disabilities Act of 1990*, 38 BRANDEIS L.J. 777, 777 (2000) ("One study estimates the number of American couples dealing with infertility will be 6.3 million in the year 2000, and approximately 7.7 million in 2025."); Shorge Sato, Note, *A Little Bit Disabled: Infertility and the Americans with Disabilities Act*, 5 N.Y.U. J. LEGIS. & PUB. POL'Y 189, 193 (2001).

2 "Now Sarai Abram's wife bare him no children . . . and Sarai said unto Abram, Behold now, the LORD hath restrained me from bearing . . ." *Genesis* 16:1-2.

3 See, e.g., Aaron C. McKee, Note, *The American Dream—2.5 Kids and a White Picket Fence: The Need for Federal Legislation to Protect the Insurance Rights of Infertile Couples*, 41 WASHBURN L.J. 191, 194 (2000).

4 See *id.*

Yet this advanced technology comes with a hefty price tag.⁵ Funding a chance to become a parent can break the bank.⁶ Health insurance, the traditional answer to medical catastrophes, provides little to no coverage for assisted reproductive technologies, or ART.⁷ This forces the vast majority of infertile couples who undergo ART to pay thousands of dollars, out of pocket, to pursue their goal of parenthood.⁸

Existing simultaneously with man's inherent urge to reproduce is the mundane arena of federal income taxes—an unlikely combination, for certain. Yet Congress has created provisions in the Tax Code to aid taxpayers in special circumstances.⁹ These provisions, called tax expenditures, act as revenue losses for the federal government in order to grant special tax relief to certain taxpayers.¹⁰ Additionally, tax expenditures may exist in an attempt to accurately reflect the income of the taxpayer,¹¹ such as the exclusion of scholarship income from one's taxable base.¹²

Tax policy and infertility collide in I.R.C. § 213, the deduction for extraordinary medical expenses.¹³ Generally, taxpayers may deduct out of pocket expenses for medical treatment that exceeds a percentage based numerical floor from their annual incomes.¹⁴ This Note will trace the use of ART as a response to the infertility crisis, point out the characteristics that make ART an "ideal" expense for the § 213 deduction, and then examine the implications of the intersection between the medical expense deduction and fertility treatment. Specifically, Part I sets forth the problem of infertility in America, the treatments, and the financial costs. Part II examines the current state of insurance coverage of fertility treatments, including an overview of the response from the Americans with Disabilities Act. Part III posits why assisted reproductive technologies present an exemplary case for the use of the § 213 deduction. Part IV addresses the implications of using the present deduction to subsidize fertility treatment. Finally, this Note concludes by offering a solution that allows for the use of

5 See *infra* notes 26–32 and accompanying text.

6 See *infra* notes 26–32, 154–55 and accompanying text.

7 See *infra* notes 33–42 and accompanying text.

8 See *infra* notes 38–42 and accompanying text.

9 See ALAN GUNN & LARRY D. WARD, CASES, TEXT AND PROBLEMS ON FEDERAL INCOME TAXATION 163 (5th ed. 2002).

10 *Id.*

11 See GUNN & WARD, *supra* note 9, at 166.

12 See I.R.C. § 117 (2000).

13 *Id.* § 213.

14 *Id.* § 213(a).

the medical expense deduction in a manner consistent with both legislative goals and the personal welfare of millions of individuals who cannot conceive a child.

I. INFERTILITY IN AMERICA: PREVALENCE, TREATMENT, AND FINANCIAL COSTS

One of the most tragic experiences that a couple may face is the physical inability to bear children. Infertility is medically defined as the failure to conceive within one year of unprotected intercourse or the inability to carry a pregnancy to full term.¹⁵ Under this definition, infertility affects over six million American couples,¹⁶ or ten percent of Americans of reproductive age.¹⁷ Infertility is on the rise in this country, placing an increasing number of people into a monthly cycle of hope and despair.¹⁸

Fortunately, modern reproductive treatments have provided the answer for a growing number of couples.¹⁹ It is estimated that almost two million people take advantage of some type of infertility service annually.²⁰ These infertility treatments include drug therapy, artificial insemination, gestational carriers, and a group of embryo transfer technologies known collectively as assisted reproductive technologies, or ART.²¹ ART consists of gamete intra fallopian transfer (GIFT), zygote intra fallopian transfer (ZIFT), and in vitro fertilization (IVF).²² IVF, GIFT, and ZIFT are similar treatments that involve stimulation of the ovaries, surgical egg retrieval, combining the eggs and sperm in a laboratory, and development of the embryo in the uterus.²³ This era of technology driven fertility procedures has grown dramatically and shows no signs of abating—American doctors performed almost thirty

15 McKee, *supra* note 3, at 192.

16 Roche, *supra* note 1, at 215.

17 McKee, *supra* note 3, at 192.

18 Flanigan, *supra* note 1, at 777; Sato, *supra* note 1, at 193.

19 For consistency, I refer to infertile *couples* throughout this Note. Of course, many single men and women face infertility as individuals, and every concern raised in this Note applies equally to their plight.

20 Flanigan, *supra* note 1, at 779.

21 *See id.*

22 *See id.* at 780. This Note will focus only on the implications of the use of such embryo transfer technologies to treat infertility. This is not to undermine the fact that most infertile couples find cost effective success through fertility drugs and artificial insemination; however, this Note considers the implications of the most extreme cases of expensive, high-tech fertility treatment only. *See id.* (noting the effectiveness of fertility drugs and artificial insemination).

23 *See* McKee, *supra* note 3, at 194.

times more ART procedures in 1998 than in 1985.²⁴ As rates of infertility continue to increase,²⁵ the potential use of ART seems limitless.

However, most of these advanced fertility treatments are quite costly. Such costs can be difficult to quantify, especially when intertwined with the costs of diagnosis.²⁶ Generally, high-tech artificial reproductive technologies cost approximately \$10,000 for each attempt.²⁷ In this country, the estimated cost per IVF cycle in 2001 was \$9226,²⁸ and the average success rate of IVF is 20% per cycle.²⁹ The cost per live birth of a baby conceived with ART has been estimated at close to \$60,000,³⁰ yet this figure does not account for the age of the mother. Since pregnancy rates decline and incidents of miscarriage rise with age, IVF costs per live birth are estimated at more than three times higher for women over forty than for women under thirty.³¹ Overall, infertile couples spend at least \$1 billion dollars every year in their quest to become biological parents—a figure that has increased over 500% in the past two decades.³²

Infertility is an increasing problem for many American couples. Modern medicine has advanced significant treatments to address the issue, but these treatments can break the bank. Even with such a high price tag, the amount of couples enduring ART grows each year. How can these couples, desperate to achieve a successful pregnancy, afford such treatment? Health insurance seems to be the only answer. But how has the insurance industry responded to the demand for coverage of assisted reproductive technology?

24 Patricia Katz et al., *The Economic Impact of the Assisted Reproductive Technologies*, 4 NATURE CELL BIOLOGY 1, S29 (2002), available at <http://www.nature.com/cgi-taf/dynapage.taf?file=/fertility/content/full/ncb-nm-fertilitys29.html>. ART procedures performed in the United States have increased from 2389 in 1985 to 61,294 in 1998. See *id.*

25 Erin Lynn Connolly, Note, *Constitutional Issues Raised by States' Exclusion of Fertility Drugs from Medicaid Coverage in Light of Mandated Coverage of Viagra*, 54 Vand. L. Rev. 451, 461 & n.55 (2001).

26 Advanced Reproductive Care, Inc., *Effectiveness of Treatment with Donor Gametes*, at http://www.arcfertility.com/infertility/treatment_donor_gametes.html (last visited Feb. 4, 2004).

27 McKee, *supra* note 3, at 195.

28 See Katz et al., *supra* note 24, at S30.

29 Advanced Reproductive Care, Inc. *supra* note 26.

30 See Katz et al., *supra* note 24, at S30.

31 *Id.* The median age for women undergoing IVF is thirty-six. *Id.*

32 Kevin Yamamoto & Shelby A.D. Moore, *A Trust Analysis of a Gestational Carrier's Right to Abortion*, 70 FORDHAM L. REV. 93, 103 n.42 (2001).

II. THE CURRENT STATE OF INSURANCE COVERAGE FOR FERTILITY TREATMENT

A. *Federal and State Legislation*

Infertile couples who turn to their employer insurance plans to cover their fertility efforts often encounter a closed door. Only one in four employers cover some form of fertility services, and ARTs, the most expensive fertility treatments, are unlikely to be included.³³ As requests to individual employers have fallen upon deaf ears, proponents of infertility rights turned to the legislature to request fertility coverage under employer health plans. At both the federal and state levels, lobbyists have encouraged legislation that requires coverage of assisted reproductive technology in employee health plans.

Efforts to implement such a sweeping mandate have been unsuccessful at the federal level. For instance, in 2001 Representative Robert Andrews of New Jersey introduced The Equity and Fertility Coverage Act.³⁴ The bill was intended to assure equitable treatment of fertility and impotence in health care coverage under group health plans and health benefits programs.³⁵ In practice, such legislation would have required insurance providers covering treatment for impotence to cover fertility treatment; however, the provider could have capped the amount of coverage, or chosen to cover neither impotence nor infertility.³⁶ House subcommittees on health, labor-management relations, and agency organization considered H.R. 568, yet the bill failed to emerge from any committee and stalled a month after its initial introduction.³⁷

Under state legislation, insurance coverage of fertility treatments tends to be the exception rather than the rule.³⁸ Only two states, Massachusetts and Rhode Island, have enacted legislation that requires broad insurance coverage for fertility treatments.³⁹ These statutes demand that any policy which includes pregnancy services must also cover the diagnosis and treatment of infertility.⁴⁰ Although thirteen states mandate some coverage of infertility treatments, these require-

33 *Id.* at 104 n.43.

34 The Equity in Fertility Coverage Act of 2001, H.R. 568, 107th Cong. (2001).

35 *Id.*

36 *Id.* § 714.

37 See Library of Cong., *Bill Summary and Status for the 107th Congress, H.R. 568*, at <http://thomas.loc.gov/bss/d108query.html> (last visited Feb. 11, 2004) (on file with author).

38 Sato, *supra* note 1, at 197.

39 Yamamoto & Moore, *supra* note 32, at 104 n.44.

40 See *id.*

ments do not encompass employer funded health benefit plans because of the Employee Retirement Income Security Act.⁴¹ In the thirty-seven states without any laws for infertility coverage, infertile couples pay for the treatment largely out of their own pockets.⁴²

B. *The Americans with Disabilities Act*

As advocates of mandatory fertility coverage have found little success in legislating the issue directly, proponents have attempted to apply existing federal legislation, the Americans with Disabilities Act, to the infertile population.

Congress created the Americans with Disabilities Act (ADA or the Act) in 1990 to respond to a history of civil rights discrimination against the disabled population.⁴³ Among its numerous provisions, the Act forbids employers from discriminating in the allocation of workplace benefits between disabled and nondisabled employees.⁴⁴

With the advent of federal protection for disabled workers, infertile women seized upon the legislation as an answer to their medical needs. In the past decade, infertile women have filed lawsuits against their employers alleging that certain workplace conditions violate the ADA.⁴⁵ Battles have been waged over a television station discharging a

41 Sato, *supra* note 1, at 197 (explaining the limits of certain state mandates).

42 See *id.*

43 See Americans with Disabilities Act, 42 U.S.C. § 12,101 (2000).

44 See *id.* § 12,112. Determining the precise workplace benefits that fall under the scope of the ADA is a topic unto itself for commentary and controversy. The scope of such a debate exceeds the inquiry of this Note. The controversy includes such questions as whether insurance plans fall under Title I or Title III of the ADA, what policies constitute discrimination in the context of insurance, whether the ADA governs the disparate effects of facially neutral policies, and the scope of the ADA's jurisdiction within and across various disabilities. For purposes of this Note, it is enough to rest on the general consensus that the ADA forbids discrimination against disabled employees in the receipt of workplace benefits. For insight into this vast arena, see generally Jeffrey S. Manning, *Are Insurance Companies Liable Under the Americans with Disabilities Act?*, 88 CAL. L. REV. 607 (2000) (arguing that the ADA forbids disability based discrimination in selling insurance policies and defines discrimination as making disability based insurance decisions without consulting actuarial tables); Jesse A. Langer, Note, *Combating Discriminatory Insurance Practices: Title III of the Americans with Disabilities Act*, 6 CONN. INS. L.J. 435 (2000) (concluding that Title III of the ADA should be construed as allowing claims for discriminatory insurance practices); Luke A. Sobota, Comment, *Does Title III of the Americans with Disabilities Act Regulate Insurance?*, 66 U. CHI. L. REV. 243 (1999) (arguing that the ADA requires only physical access to public accommodations and does not cover insurance).

45 See, e.g., *LaPorta v. Wal-Mart Stores, Inc.*, 163 F. Supp. 2d 758 (W.D. Mich. 2001); *Saks v. Franklin Covey Co.*, 117 F. Supp. 2d 318 (S.D.N.Y. 2000); *Neimeier v. Tri-State Fire Prot. Dist.*, No. 99-C-7391, 2000 WL 1222207 (N.D. Ill. Aug. 24, 2000);

news anchor for excessive absences during her fertility treatment,⁴⁶ a pharmacist requesting extra sick days to undergo in vitro fertilization,⁴⁷ and employees questioning the lack of fertility treatment coverage in their employer health plans.⁴⁸

For plaintiffs to win, they must convince the courts of two conditions. First, infertility must constitute a protected disability under the ADA. Second, the ADA must prevent employers from discriminating against the disabled by refusing to accommodate fertility treatment in their insurance plans. In this budding area of the law, most litigation has focused on the first issue: whether infertility qualifies as a disability under the ADA. The Supreme Court may have resolved this dispute over the definition of disability in 1998 with *Bragdon v. Abbot*,⁴⁹ yet questions abound over the applicability of *Bragdon* to the world of infertility. This Note will now examine the debate over whether the Americans with Disabilities Act requires employers to cover fertility treatment in their employee insurance plans.

1. Is Infertility a Disability Under the ADA?

For the past decade, courts have encountered the intersection of the Americans with Disabilities Act and the condition of medical infertility. A standard fact pattern for such cases involves an infertile plaintiff alleging that the lack of infertility treatment coverage in an employee insurance plan violates the ADA.⁵⁰ To begin, courts examine whether the infertile plaintiff suffers from a disability as defined by federal legislation.⁵¹ If the infertile plaintiff is not disabled, she cannot find relief under the ADA.⁵²

The ADA defines a disability as "a physical or mental impairment that substantially limits one or more of the major life activities of [an] individual."⁵³ For analysis, we may break the definition into two parts:

Soodman v. Wildman, Harrold, Allen & Dixon, No. 95-C-3834, 1997 WL 106257 (N.D. Ill. Feb. 10, 1997); Krauel v. Iowa Methodist Med. Ctr., 915 F. Supp. 102 (S.D. Iowa 1995); Erickson v. Bd. of Governors, 911 F. Supp. 316 (N.D. Ill. 1995); Zatarain v. WDSU-Television, Inc., 881 F. Supp. 240 (E.D. La. 1995).

46 *Zatarain*, 881 F. Supp. at 241-42.

47 *LaPorta*, 163 F. Supp. 2d at 763.

48 *Saks*, 117 F. Supp. 2d at 320-21; *Krauel*, 915 F. Supp. at 105.

49 524 U.S. 624 (1998).

50 *Saks*, 117 F. Supp. 2d at 320-21; *Niemeier*, 2000 WL 1222207, at *1; *Krauel*, 915 F. Supp. at 105-06.

51 See *supra* note 45.

52 See, e.g., 42 U.S.C. § 12,112(a) (2000) (prohibiting discrimination against only "qualified individual[s] with a disability because of the disability").

53 *Id.* § 12,102 (2)(A). The statute lists two other parts to the definition. The term disability also means "a record of such an impairment; or being regarded as

(1) whether infertility is "a physical or mental impairment," and (2) whether the impairment interferes with a "major life activity."

One judge found the answer self-evident as he held that infertility was a clear physical impairment.⁵⁴ Other courts give the issue a bit more reflection, and have looked to the ADA's federal regulations for help in determining what constitutes a physical or mental impairment.⁵⁵ Under federal regulations, an impairment is "a physiological disorder . . . affecting one or more of the following body systems[,] . . . [including the] reproductive [system]."⁵⁶ While a physical abnormality causing infertility satisfies this definition,⁵⁷ some couples do not have a medical explanation for their infertility.⁵⁸ However, because courts generally have accepted that infertility is a physical impairment,⁵⁹ we will assume that the typical infertile plaintiff can satisfy this first branch of the ADA definition.

If a plaintiff fulfills the first clause of the ADA definition, the next question turns upon whether infertility substantially limits a major life activity. Most litigation in fertility cases has centered on whether re-

having such an impairment." *Id.* § 12,102 (2)(B)–(C). Since most of the litigation and commentary has focused on the first part of the definition, the inquiry of this Note will be similarly limited to the first strand.

54 "It defies common sense to say that infertility is not a physiological disorder" *Pacourek v. Inland Steel Co.*, 916 F. Supp. 797, 801 (N.D. Ill. 1996).

55 *See id.*; *Erickson v. Bd. of Governors*, 911 F. Supp. 316, 321 (N.D. Ill. 1995); *Zatarain v. WDSU-Television, Inc.*, 881 F. Supp. 240, 242 (E.D. La. 1995).

56 29 C.F.R. § 1630.2(h)(1) (2003).

57 Infertility is a medical condition recognized by the American College of Obstetrics and Gynecologists and defined as "the inability to conceive within one year or the inability to carry a pregnancy." *McKee*, *supra* note 3, at 192 (quoting I. Ray King, *Treating Infertility Not That Expensive*, KNOXVILLE NEWS-SENTINEL, Oct. 17, 2000, at A9).

58 "Approximately twenty percent of all infertility [sic] cannot be explained." *Id.* at 193. Presumably, some of these cases of infertility are due to the inevitable consequences of aging, and not to any physical impairment with the reproductive system. Under the federal regulations, menopausal infertility would probably not fulfill the definition of a physical impairment because it is not a physical abnormality of the reproductive system (assuming that the woman has reached an accepted age for menopause.) *See McGraw v. Sears, Roebuck & Co.*, 21 F. Supp. 2d 1017, 1021 (D. Minn. 1998) (noting that menopause itself is not a disability under the ADA because it is an "entirely normal consequence of human aging"). *But see Saks v. Franklin Covey Co.*, 117 F. Supp. 2d 318, 326 n.6 (S.D.N.Y. 2000) (refraining from addressing the "fascinating question" of whether premature menopause, "the abnormally early onset of an otherwise normal bodily process," constitutes a disability under the ADA).

59 *See, e.g., Zatarain*, 881 F. Supp. at 243 ("[T]he Court cannot find as a matter of law that plaintiff does not have an impairment in the nature of a physiological disorder of the reproductive system.").

production is a major life activity as defined by the ADA.⁶⁰ If reproduction is a major life activity, then infertility fulfills the second element of the test for a disability.

The question of whether reproduction is a major life activity has dominated the judicial focus of this field for the past decade, with federal courts divided on the answer. While the ADA does not define a major life activity, federal regulations enumerate the standards.⁶¹ The regulation states that “[m]ajor [l]ife [a]ctivities means functions such as caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working.”⁶² Defendants have used this definition to argue that Congress meant to exclude reproduction as a major life activity. They claim that the list of examples stresses independent activities, while reproduction requires participation from two individuals.⁶³ Judges have also used the regulations to hold that reproduction, unlike breathing, seeing, or hearing, is a lifestyle choice, and not a necessary life activity.⁶⁴ Courts also distinguish reproduction from the list of other major life activities by its less frequent occurrence.⁶⁵

However, policy problems may arise by denying reproduction the status of a major life activity. One opinion points out that denying reproduction the status of a major life activity is inconsistent with protections Congress has afforded to pregnancy and childbearing, in legislation such as the Family and Medical Leave Act⁶⁶ as well as the Pregnancy Discrimination Act.⁶⁷ In light of these federal protections, a narrow interpretation of reproduction reduces it to nothing more than a lifestyle choice.

With federal courts divided on the issue of whether reproduction is a major life activity, the issue was ripe for the Supreme Court to intervene. They did so, but in a manner quite different than in the traditional infertility context.

60 See *Pacourek v. Inland Steel Co.*, 916 F. Supp. 797, 801–04 (N.D. Ill. 1996); *Krauel v. Iowa Methodist Med. Ctr.*, 915 F. Supp. 102, 106–08 (S.D. Iowa 1995); *Zatarain*, 881 F. Supp. at 243–44.

61 See 29 C.F.R. § 1630.2(i).

62 *Id.*

63 See *Erickson v. Bd. of Governors*, 911 F. Supp. 316, 321 (N.D. Ill. 1995).

64 See *Krauel*, 915 F. Supp. at 106.

65 See *id.*; *Zatarain*, 881 F. Supp. at 243.

66 See 29 U.S.C. § 2601 (2000).

67 42 U.S.C. § 2000e(k) (2000); see also *Soodman v. Wildman, Harrold, Allen & Dixon*, No. 95-C-3834, 1997 WL 106257, at *5 (N.D. Ill. Feb. 10, 1997).

2. *Bragdon v. Abbott*: Ending the Debate?

A specific point of contention marked the debate over whether infertility met the ADA definition of a disability. Federal courts differed on whether reproduction was a major life activity, and the Supreme Court's answer would have tremendous implications. If reproduction was a major life activity, then physical impairment substantially limiting reproduction should constitute a disability. Infertility is that physical impairment.

*Bragdon v. Abbott*⁶⁸ was not a debate over infertility. In fact, the Supreme Court made no mention of infertility in the entire opinion. *Bragdon* is a case about the rights of people who are HIV positive under the Americans with Disabilities Act.

Sidney Abbott suffered from asymptomatic HIV.⁶⁹ She alleged that her dentist, Randon Bragdon, violated the ADA by refusing to fill her cavity in his office.⁷⁰ To present a valid claim, Ms. Abbott had to qualify as a person with a disability under the ADA.⁷¹ She argued that her HIV status constituted a disability because it was a physical impairment that substantially limited a major life activity.⁷² Her impaired life activity, she argued, was her inability to reproduce.⁷³

In a five to four decision, the Court agreed with Ms. Abbott.⁷⁴ The Court held that reproduction is a major life activity, and because HIV substantially limits the ability to reproduce, people suffering from HIV are disabled under the ADA.⁷⁵ But as the focus of the case was the disability status of HIV and not of infertility, the applicability of the opinion to the infertility debate is unclear.

Even with questions regarding *Bragdon's* applicability to infertility, reproductive rights proponents hailed *Bragdon* as a tremendous victory.⁷⁶ Some scholars viewed the majority's key holding that reproduction is a major life activity as an end to the debate among lower courts over the status of infertility as a disability.⁷⁷ However, even with

68 524 U.S. 624 (1998).

69 *Id.* at 628.

70 *Id.* at 629.

71 *See id.*

72 *See id.* at 632-42.

73 *Id.* at 637. While not physically impossible to reproduce, Ms. Abbott's attempts to reproduce would pose a severe health risk both to her sexual partner and to her future child. *Id.* at 639-40.

74 *Id.* at 627.

75 *See id.* at 637-42.

76 Sato, *supra* note 1, at 189-90.

77 *See id.*

Bragdon's definition of reproduction as a major life activity, the legal battle for ADA protections for infertility continued.

3. *Bragdon's* First Test: *Saks v. Franklin Covey Co.*

A case arose just months after *Bragdon* that addressed its holding in the infertility context. In *Saks v. Franklin Covey Co.*,⁷⁸ Rochelle Saks brought suit against her employer, a book publisher.⁷⁹ Ms. Saks suffered from medically diagnosed infertility and underwent costly surgical treatment, which her employer health plan refused to cover.⁸⁰ Saks sued her employer, Franklin Covey, alleging (1) that she was disabled under the ADA, and (2) that Covey's health benefits plan violated the ADA by discriminating against her disability in excluding "surgical impregnation procedures" such as in vitro fertilization and artificial insemination.⁸¹

Leading up to the case, legal pundits expected the controversy to center around the ADA definition of a disability.⁸² As *Bragdon* held that reproduction is a major life activity, it seemed logical that the physical limitation of this major life activity should fulfill the legal definition of a disability.⁸³ Furthermore, if infertility is a disability, the ADA should prevent discrimination against infertility in employer health plans.⁸⁴

Much to the surprise of the legal community, the "infertility as a disability" question provided the beginning of the analysis, but not the end of the matter. The district judge held that Ms. Saks was indeed disabled under the ADA because she suffered from infertility, and this gave her standing to bring the case.⁸⁵ However, Ms. Saks lost her case on summary judgment.⁸⁶

The court dismissed Ms. Saks' case because she failed to prove discrimination, a required element for an ADA claim.⁸⁷ Discrimina-

78 117 F. Supp. 2d 318 (S.D.N.Y. 2000), *aff'd in part and remanded in part*, 316 F.3d 337 (2d Cir., 2003).

79 *Id.* at 319–21.

80 *Id.* at 322–23.

81 *Id.* at 319–21.

82 *See* Sato, *supra* note 1, at 208.

83 *See id.*

84 *See id.*

85 *See Saks*, 117 F. Supp. 2d at 324.

86 *Id.* at 321.

87 *See id.* at 326–27. The ADA prohibits discrimination against "a qualified individual with a disability because of the disability of such individual in regard to job application procedures, the hiring, advancement, or discharge of employees, employee compensation, job training, and other terms, conditions, and privileges of employment." 42 U.S.C. § 12,112(a) (2000).

tion did not exist in her claim because Ms. Saks had equal access to the same insurance policy as her nondisabled coworkers; the plan excluded coverage for surgical impregnation procedures for every employee, regardless of their fertility status.⁸⁸ The court relied on precedent from various circuit courts in holding that "insurance distinctions that apply equally to all insured employees do not discriminate on the basis of disability."⁸⁹ The opinion stressed that insurers are under no obligation to provide equal benefits across disabilities, even though the limitation "hits infertile employees like Ms. Saks harder than it hits other employees"⁹⁰ Because all employees faced the same limitation, the court did not find the requisite discrimination necessary for an ADA claim.

Advocates of infertility rights criticized the decision.⁹¹ Yet *Saks* has remained the law for determining the applicability of the ADA to infertility. While infertility may constitute a disability under the ADA, the ADA does not require employers to cover fertility treatment in employee health insurance plans.

III. ASSISTED REPRODUCTIVE TECHNOLOGIES: CONDITIONS RIPE FOR THE MEDICAL EXPENSE DEDUCTION

As this Note has examined, infertility is a widespread, growing problem in this country, and assisted reproductive technology is becoming an increasingly popular method to treat infertility. ART is as costly as it is prevalent, with the price of a live birth estimated at \$60,000 for a single child.⁹² With the incidents of fertility treatment on the rise, how can American couples pay for the expense? Federal and state laws do not require employers to cover ART in their employee health plans. Spurned by the legislature, fertility advocates attempted to apply the protections of the Americans with Disabilities Act to infertile couples. After years of litigation and a nod from the Supreme Court, the current law states that the ADA may protect infertile patients in some areas, but it does not mandate employer health insurance for fertility treatments.

88 See *Saks*, 117 F. Supp. 2d at 326–27.

89 *Id.*

90 *Id.* at 327.

91 See, e.g., Valerie Gutmann, *Assisted Reproductive Technologies: Failure to Cover Does Not Violate ADA, Title VII, or PDA*, 31 J.L. MED. & ETHICS 314, 316 (2003) ("[A]lthough *Saks* can be seen as a step in the right direction by recognizing infertility as a disability under the ADA, it continues the restriction of coverage under employer benefits plans."); Sato, *supra* note 1, at 206–23.

92 See Katz et al., *supra* note 24, at 530.

The answer to this inquiry seems clear: infertile couples pay for the chance at parenthood out of their own pockets. Statistics show that patients bear approximately 85% of fertility costs themselves because they lack coverage by health insurance plans.⁹³ One author described how couples pay for the expensive treatment as follows: "The first step usually involves exhausting their savings. The next step is signing up for a host of credit cards and charging up to their credit limit. If they can, they usually then borrow from relatives or friends."⁹⁴ At roughly \$60,000 per live birth,⁹⁵ the price of a child can certainly break the bank, but for many prospective parents, the chance to conceive outweighs any price tag.

However, couples that pay for infertility treatment out of pocket can find compensation for these expenses in another area. In the next section, this Note will examine why the nature of fertility treatments creates an ideal situation for the use of a federal income tax deduction for medical expenses. The remainder of this Note focuses on both the use and implications of such a deduction in the context of assisted reproductive technology.

A. *The U.S. Federal Income Tax System*⁹⁶

Article I, § 8 of the Constitution allows Congress to "lay and collect Taxes, Duties, Imposts and Excises . . ."⁹⁷ Since its inception, the modern income tax has become the federal government's primary source of revenue. In the year 2000, individual income taxes amounted to \$1.1 trillion dollars in revenue, or 53% of the total revenue of all tax collections.⁹⁸

Yet this amount could be greater. The government has purposely chosen not to tax the entirety of an individual's gross income. The Internal Revenue Service taxes only the taxable income of the tax-

93 Yamamoto & Moore, *supra* note 32, at 104.

94 *Id.* at 104 n.43 (quoting Esther B. Fein, *Calling Infertility a Disease, Couples Battle with Insurers*, N.Y. TIMES, Feb. 22, 1998, at A1).

95 For a discussion on the costs and success of ART, see *supra* Part I.

96 This extremely simplified view of the federal income tax system is meant to be the broadest of summaries. I do not suggest that this begins to address the complexities of the marginal and progressive rate systems, the differences between itemized or above-the-line deductions, or the decision of taxpayers to itemize their deductions. For greater detail on these subjects, see Jeffrey H. Kahn, *Personal Deductions—A Tax "Ideal" or Just Another "Deal"?*, 2002 L. REV. M.S.U.-D.C.L. 1.

97 U.S. CONST. art. I, § 8, cl. 1.

98 GUNN & WARD, *supra* note 9, at 5. Other tax collections come from corporate income tax, employment taxes, estate and gift taxes, and excise taxes. *Id.*

payer, and not the gross income—essentially all acquired wealth over a taxable year.⁹⁹

Taxable income is calculated by subtracting a taxpayer's deductions from their gross income.¹⁰⁰ Generally, subject to limitations, the Internal Revenue Code allows a taxpayer to take deductions for certain nonbusiness expenditures and losses.¹⁰¹ These deductions are called "personal deductions."¹⁰² Examples of personal deductions include deductions for alimony, charitable contributions, and medical costs.¹⁰³ By deducting, or subtracting, these deductions from a taxpayer's total amount of gross income, the taxpayer is left with a smaller taxable income. The Internal Revenue Code will tax this lesser taxable income, essentially forfeiting the deductions that the Code could levy a tax upon if they were to tax the entire amount of a taxpayer's gross income.

These revenue losses resulting from federal tax provisions may be characterized as tax expenditures.¹⁰⁴ A tax expenditure is a feature of the tax law that exists to further some nontax goal or to aid taxpayers in special circumstances.¹⁰⁵ Expenditures may take the form of (1) exclusions, exemptions, and deductions; (2) preferential tax rates; (3) credits; and (4) deferrals of tax.¹⁰⁶ Expenditures may be viewed as the equivalent of a simultaneous collection of revenue and a direct budget outlay of the same amount to the taxpayer.¹⁰⁷ As such, one may characterize an expenditure as a form of subsidy by the federal government. Because tax expenditures are generally enacted as permanent legislation, it is important that they be given periodic consideration to determine whether they continue to meet the goals for their establishment.¹⁰⁸

B. I.R.C. § 213: The Medical Expense Deduction

One example of such a tax expenditure is the deduction for medical expenses from personal taxable income. The income tax deduction for medical expenses was created over sixty years ago under I.R.C.

99 *See id.* at 39.

100 *Id.*

101 *Id.*

102 *See id.*

103 *See id.*

104 *See id.* at 165.

105 *Id.*

106 COMM. ON THE BUDGET, 94th CONG., TAX EXPENDITURES 2 (Comm. Print 1976).

107 *Id.* at 1.

108 *Id.* at 2.

§ 213(a).¹⁰⁹ This provision of the Internal Revenue Code states that “there shall be allowed as a deduction the expenses paid during the taxable year, not compensated for by insurance or otherwise, for medical care of the taxpayer, his spouse, or a dependent . . . to the extent that such expenses exceed 7.5 percent of adjusted gross income.”¹¹⁰

Section 213 allows a taxpayer to deduct expenses for medical care of the taxpayer, his spouse, or his dependents if insurance does not cover such expenses.¹¹¹ Qualified expenses can be deducted only to the extent that they exceed 7.5% of the taxpayer’s adjusted gross income, and only if the taxpayer elects to itemize his deductions.¹¹²

The § 213 tax deduction will cover expenses for fertility treatment¹¹³ to the extent that such treatment is not covered by insurance, and to the extent that the treatment exceeds 7.5% of the taxpayer’s adjusted gross income. As discussed previously, insurance rarely covers fertility treatment.¹¹⁴ The high cost of such treatment will often place these expenses above a taxpayer’s 7.5% income floor.¹¹⁵

Additionally, the IRS has made it clear in both the text of the Code and in a supplemental publication that fertility treatment qualifies as a medical expense for the use of the deduction. Section 213(d)(1)(A) defines medical care as amounts paid “for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body.”¹¹⁶ As discussed previously, courts have struggled over whether to call infertility a disease.¹¹⁷ However, fertility treatment certainly seems to satisfy the requirement of medical care paid for the purpose of affecting a function of the body. In the instance of fertility treatment, such expenses affect the function of reproduction. As such, the plain language of § 213 supports the belief that the deduction covers fertility treatment expenses.

109 Louis Alan Talley, *Medical Expense Deduction: History and Rationale for Past Changes*, 2001 CRS REP. FOR CONG. 1, 2.

110 I.R.C. § 213(a) (2000).

111 *Id.*

112 *Id.*; see also I.R.C. § 63(d) (explaining itemized deductions).

113 See *infra* notes 118–21 and accompanying text.

114 See *supra* Part II.A. Patients bear 85% of the costs of fertility treatment out of pocket. See *supra* note 93 and accompanying text.

115 See *supra* Part I. As a whole, medical expenses must amount to over 7.5% of the taxpayer’s adjusted gross income to qualify for the deduction. The 7.5% is a floor; only expenses that exceed this 7.5% base of adjusted gross income are counted for the deduction. See I.R.C. § 213(a).

116 I.R.C. § 213 (d)(1)(A).

117 See *supra* Part II.B.1.

The IRS addressed this interpretation of § 213 in *Publication 502, Medical and Dental Expenses*,¹¹⁸ by answering the question: "What Medical Expenses are Deductible?"¹¹⁹ In an extensive list of deductible expenses, the IRS includes "Fertility Enhancement."¹²⁰ It states that a taxpayer "can include in medical expenses the cost of . . . [p]rocedures such as *in vitro* fertilization . . . [and] surgery"¹²¹ Both the language of the statute and *Publication 502* support the claim that a taxpayer may deduct medical expenses for fertility enhancement, and this deduction appears to include all methods of assisted reproductive technology.

IV. IMPLICATIONS OF USING I.R.C. § 213 TO DEDUCT EXPENSES FOR ASSISTED REPRODUCTIVE TECHNOLOGY

While the plain language of both the Code and *Publication 502* support the conclusion that fertility treatments may be deducted under the medical expense deduction, it is important to consider the implications of using the deduction to subsidize any and all fertility treatment.

A. *Legislative History of I.R.C. § 213*

In 1942, Congress introduced the individual income tax deduction for medical expenses into the tax Code.¹²² Congress created the deduction during the World War II era to help taxpayers provide for essential medical services and to keep taxpayers from delaying medical treatment.¹²³ In congressional hearings, Tax Adviser Randolph E. Paul testified that "'a deduction should be allowed for extraordinary medical expenses that are in excess of a specified percentage of a family's net income.'"¹²⁴ He also testified that the amount should be limited to a specified maximum.¹²⁵ In order to be deductible under the original statute, medical expenses had to exceed 5% of a taxpayer's

118 INTERNAL REVENUE SERV., U.S. DEP'T OF THE TREASURY, PUBLICATION 502, MEDICAL AND DENTAL EXPENSES (2002). The U.S. Treasury Department creates such publications to aid the taxpayer in preparing annual returns. See *id.* at 1.

119 *Id.* at 4-12.

120 *Id.* at 6.

121 *Id.*

122 Talley, *supra* note 109, at 2.

123 See *id.* at 3.

124 *Id.* (quoting *Revenue Revision of 1942: Hearings on Revenue Revision of 1942 Before the House Comm. on Ways and Means, 77th Cong. 1612 (1942)* (statement of Randolph E. Paul, Tax Advisor to the Sec'y of the Treasury)).

125 *Id.*

net income and were limited to a maximum deduction of \$2500.¹²⁶ The 5% floor meant that taxpayers could deduct only the medical expenses that were truly “extraordinary,” yet the \$2500 ceiling reduced the revenue loss associated with the deduction.¹²⁷ The medical expense deduction began, and remains, as an exception to the general rule that personal expenses should not be deductible.¹²⁸

In the six decades since the original enactment of I.R.C. § 213, both the floor and the ceiling on the deduction have undergone extensive change. This Note will first trace the legislative history behind the floor of the deduction.

1. Section 213’s Threshold Floor

Shortly after the deduction’s original enactment, the legislature adjusted the threshold limitation.¹²⁹ The Revenue Act of 1951 removed the 5% limitation for medical expenses if the taxpayer was over age sixty-five.¹³⁰ In passing this amendment, the Committee on Finance saw that the elderly have both a decreased earning capacity and increased medical expenses, and believed that disallowance of the deduction due to a percentage floor could accentuate this hardship.¹³¹ Without a 5% floor, taxpayers over sixty-five years of age could deduct even the smallest amounts of medical expenses. In 1954, Congress continued the trend by lowering the threshold for deductibility from 5% to 3% for taxpayers below age sixty-five.¹³² As such, early legislative trends apparently aimed to increase the use of the deduction for medical expenses by lowering the threshold for eligibility.

Yet recent amendments to the medical expense deduction seem to reflect a change in this policy. In 1982, the eligibility floor for deductible medical expenditures was raised from 3% to 5% of adjusted gross income.¹³³ The primary rationale for the change was a concern that the deduction no longer reflected “‘economic hardship, beyond the individual’s control, which reduces the ability to pay Federal in-

126 *Id.*

127 *See id.*

128 *Id.*

129 *See id.* at 4–5.

130 *Id.* at 4.

131 *Id.* at 5.

132 *Id.*

133 *Id.* at 10. (citing *Social Security Amendments of 1965: Report on H.R. 6675 Before the House Comm. on Ways and Means*, 89th Cong. 136–37 (1965)).

come tax.'"¹³⁴ In addition, the government did not desire to provide an incentive for taxpayers to further their health care spending through extensive deductions for medical expenses.¹³⁵ These rationales carried forth to the Tax Reform Act of 1986, when Congress increased the floor of the deduction to the present 7.5%.¹³⁶ The rationale for increasing the floor was provided by the Joint Committee on Taxation:

In raising the deduction floor to 7.5 percent of the taxpayer's adjusted gross income, the Act retains the benefit of deductibility where an individual incurs extraordinary medical expenses . . . that are not reimbursed through health insurance or Medicare. Thus, the Act continues deductibility if the unreimbursed expenses for a year are so great that they absorb a substantial portion of the taxpayer's income and hence substantially affect the taxpayer's ability to pay taxes.¹³⁷

The initial amendments to § 213 attempted to expand the use of the deduction by lowering the threshold floor. In contrast, since 1982, Congress has attempted to limit the use of the deduction by raising the floor for eligibility. Currently, taxpayers must spend more than 7.5% of their adjusted gross income on medical expenses before the first dollar of expenses may be taken as a deduction. According to the legislature, such a floor exists so that taxpayers will only deduct medical expenses that are large enough to substantially affect taxpayers' ability to pay their income taxes.¹³⁸

2. Considerations of Vertical Inequity

Until now, this Note has considered the 7.5% floor for the medical expense deduction in the abstract. However, using the deduction for fertility treatment raises interesting effects in its application. As applied, subsidizing fertility treatment through the medical expense deduction results in the problem of "vertical inequity." Vertical *equity* refers to the relative amount of taxes paid by individuals with different incomes, and requires that "those with greater ability to pay actually

134 *Id.* at 11 (quoting JOINT COMM., 97TH CONG., GENERAL EXPLANATION OF THE REVENUE PROVISIONS OF THE TAX EQUITY AND FISCAL RESPONSIBILITY ACT OF 1982, at 24-25 (Comm. Print 1983)).

135 *See id.*

136 *Id.* at 12.

137 *Id.* (citing JOINT COMM., 100TH CONG., GENERAL EXPLANATION OF THE TAX REFORM ACT OF 1986, at 50-51 (Comm. Print 1987)).

138 *See id.*

pay more tax."¹³⁹ Accordingly, vertical *inequity* means that taxpayers with a lesser ability to pay receive a greater burden of taxation than is proportional to their ability.¹⁴⁰ As a policy goal, the Internal Revenue Code should minimize vertical inequity whenever possible.¹⁴¹

However, I.R.C. § 213 promotes vertical inequity by its current 7.5% floor. The Code allows for a personal income tax deduction only to the extent that medical expenses exceed 7.5% of a taxpayer's adjusted gross income. In the context of fertility treatment, however, § 213 will promote vertical inequity because taxpayers of a higher bracket are more likely to spend money on expensive, aggressive treatment simply because they have the income to spend. Data supports the theory that higher income couples spend more of their income on fertility treatment than lower income couples.¹⁴² This means that the higher income couples are more likely to exceed the 7.5% threshold for eligibility to claim the deduction.¹⁴³ Low income taxpayers are unlikely to qualify for the deduction because they cannot afford to spend over 7.5% of their income on treatment. As such, the wealthier infertile taxpayer can both afford expensive, out of pocket ART and will likely have such treatment subsidized through the tax system, where her lower income counterpart finds neither benefit. Such vertical inequity contradicts a stated goal of the deduction, which aims to reflect the individual ability to pay income taxes.¹⁴⁴

139 Tracy A. Kaye, *Sheltering Social Policy in the Tax Code: The Low-Income Housing Credit*, 38 VILL. L. REV. 871, 931 (1993).

140 See *id.*

141 See Cynthia E. Garabedian, Note, *Tax Breaks for Higher Education: Tax Policy or Tax Pandering?*, 18 VA. TAX REV. 217, 230 (1998).

142 See Leslie Bender, *Genes, Parents, and Assisted Reproductive Technologies: ARTs, Mistakes, Sex, Race, & Law*, 12 COLUM. J. GENDER & L. 1, 38 n.109 (2003) (noting the socioeconomic discrepancies between income and the use of ART).

143 But see James W. Colliton, *The Medical Expense Deduction*, 34 WAYNE L. REV. 1307, 1310 (1988). Colliton argues that the 7.5% limitation disproportionately benefits low income taxpayers because a low income taxpayer can exceed 7.5% of his adjusted gross income with lower medical expenses. He notes that a high income taxpayer may spend exactly the same amount on medical care, but receive no deduction because he has a higher adjusted gross income. See *id.* While I agree with this point generally, I believe that these circumstances change in the realm of assisted reproductive technology. Low income taxpayers generally do not elect to pay for these expensive, optional treatments, but the wealthy taxpayers who choose to do so may receive an added benefit from this deduction if their expenses exceed 7.5% of their income.

144 See *supra* notes 134–35 and accompanying text.

3. Section 213's Cap on Deductibility

In addition to the fluctuating floor, I.R.C. § 213 has undergone other important amendments throughout its history. Congress enacted the medical expense deduction in 1942 with a cap; the maximum deduction allowed for married taxpayers was \$2500.¹⁴⁵ This monetary ceiling was created to prevent incentives for extravagant health care spending.¹⁴⁶

From its creation in the 1940s until the 1960s, this ceiling was gradually heightened to reflect inflation and the rising costs of health care.¹⁴⁷ In 1965, Congress eliminated the ceiling for the deduction entirely.¹⁴⁸ Yet in eliminating the ceiling, Congress continued to express concern over creating incentives for extravagant medical expenses.¹⁴⁹ While the legislature was initially concerned with taxpayers using a limitless deduction as an incentive for medical spending, the current state of the deduction appears to reflect the realities of an increasingly expensive health care system.

4. Risks of Unlimited Fertility Treatment

In a historical context, the present incarnation of § 213 is unique in that it lacks a ceiling. What this means in the realm of fertility treatment deserves consideration. In theory, a taxpayer can spend an unlimited amount of money on fertility treatment, and so long as the treatment exceeds 7.5% of her gross income, she can continue to deduct each dollar over the 7.5% base.

However, an unlimited subsidy for fertility treatment may not reflect the goals of this expenditure. Many risks accompany ART, and these risks increase with the incidents of fertility treatment.¹⁵⁰ The likelihood of multiple births and the health complications that accompany such births increase with the use of ART.¹⁵¹ In this country,

145 Talley, *supra* note 109, at 2. The maximum deduction for single taxpayers was \$1250. *Id.* at 3 (citing *Revenue Revision of 1942: Hearing Before the House Comm. on Ways and Means*, 77th Cong. 1613 (1942)).

146 *See id.*

147 *See id.* at 2-9.

148 *See id.* at 9.

149 *See id.* at 10 (citing *Social Security Amendments of 1965: Report on H.R. 6675 Before the House Comm. on Ways and Means*, 89th Cong. 136-37 (1965)).

150 *See* Lars Noah, *Assisted Reproductive Technologies and the Pitfalls of Unregulated Biomedical Innovation*, 55 FLA. L. REV. 603, 603 (suggesting that society should "reconsider the safety and effectiveness of fertility drugs in order to combat some of the continuing problems arising from the overly aggressive use of assisted reproductive technologies, especially the health hazards associated with multifetal pregnancies").

151 *Id.* at 618-24.

three or more embryos are transferred in 80% of ART cycles;¹⁵² as a result, over one-third of the IVF births in this country result in multiple births.¹⁵³ Such multiple births generate higher costs than single births—the result of higher incidents of complications.¹⁵⁴ The average cost for a twin delivery is four times higher than for a single birth, and charges for a triplet delivery are eleven times higher, averaging over \$100,000.¹⁵⁵ It seems problematic that the subsidy of one set of medical expenses may promote further medical expenses if successful.

Drawbacks to unlimited fertility treatment exist. ART procedures raise a variety of safety concerns for the mother, including chronic side effects associated with fertility drugs, an increase in the risks of certain cancers, complications with the harvesting procedure, and higher rates of ectopic pregnancies.¹⁵⁶ ARTs are “hardly innocuous medical interventions.”¹⁵⁷ Beyond physical concerns, the psychological anguish and heartbreak of couples that undergo extensive fertility treatment increases pressure on the family relationship with each passing month.¹⁵⁸ In addition, moral and religious objections exist to the use of technology that may dispose of fertilized embryos as part of the treatment method.¹⁵⁹

Certainly, millions of couples voluntarily choose to undergo these risks for the chance at the immeasurable reward of having a child. Yet it is a separate consideration whether the federal government should allow an unlimited, uncapped financial benefit to certain couples who elect to undergo procedures with considerable risks. As the legislature intended to alleviate the costs of health care by eliminating any caps to the medical expense deduction, the implications of unlimited fertility treatment should be considered in evaluating whether § 213 meets its policy goals in this context.

B. Judicial Interpretation: “Functional Adequacy”

Until now, this Note has assumed that any fertility treatment may be easily defined as a medical expense. In reality, the scope of what the IRS will allow as a medical expense, as well as what they should allow, is unclear.

152 Katz et al., *supra* note 24, at S30.

153 *Id.*

154 *Id.*

155 *Id.*

156 Noah, *supra* note 150, at 620–21.

157 *Id.* at 621.

158 See McKee, *supra* note 3, at 192.

159 See, e.g., CATECHISM OF THE CATHOLIC CHURCH §§ 2375–2379 (2d ed. 2000).

The judiciary has addressed the scope of § 213 in contexts other than fertility treatment. Generally, taxpayers may take a deduction for medical expenses no greater than the minimum reasonable cost of "functionally adequate" treatment.¹⁶⁰ For example, a taxpayer with a spinal disorder may deduct the cost of installing a pool at her home for daily swim therapy, but cannot deduct costs attributable to architectural or aesthetic compatibility of the pool with her home.¹⁶¹

The scope of the medical expense deduction presents a problem in the infertility context, where no quantifiable adequacy exists if the only possible "cure" is a successful pregnancy. Couples spend hundreds of thousands of dollars on treatments that may carry medical risks along with the chance for success.¹⁶² Defining these limits seems to present a problem in the context of infertility, where "functionally adequate" may mean nothing short of any medical expense it takes to bear a child.

V. SUGGESTIONS TO BOTH RESTRAIN AND INCREASE THE DEDUCTIBILITY OF ART

I.R.C. § 213 allows for the deduction of medical expenses not covered by a taxpayer's insurance.¹⁶³ Section 213 only allows for a deduction to the extent that such expenses exceed 7.5% of a taxpayer's adjusted gross income—yet taxpayers may deduct an unlimited amount of expenses once they pass this threshold.¹⁶⁴ Infertility treatment presents unique issues for the § 213 deduction. The high costs of this elective treatment, along with the 7.5% threshold, place the deduction out of reach for most low income taxpayers.¹⁶⁵ This leads to a problem of vertical inequity, where wealthy taxpayers are more likely to receive a subsidy for ART than lower income taxpayers be-

160 *Ferris v. Comm'r*, 582 F.2d 1112, 1116 (7th Cir. 1978) ("[A]ny costs above those necessary to produce a functionally adequate facility are not incurred 'for medical care.'").

161 *See id.*

162 *See, e.g.*, Noah, *supra* note 150, at 603 (arguing that we should "reconsider the safety and effectiveness of fertility drugs in order to combat some of the continuing problems arising from the overly aggressive use of assisted reproductive technologies, especially the health hazards associated with multifetal pregnancies"); Sherri A. Jayson, Comment, "*Loving Infertile Couple Seeks Woman Age 18-31 to Help Have Baby. \$6,500 Plus Expenses and a Gift: Should We Regulate the Use of Assisted Reproductive Technologies by Older Women?*", 11 ALB. L.J. SCI. & TECH. 327, 327-31 (2001) (discussing the extreme costs of ART).

163 I.R.C. § 213(a) (2000).

164 *Id.*; *see also* Ron West, *Diagnose Payments for Bigger Medical Expense Deductions*, 62 PRAC. TAX STRATEGIES 289, 289 (1999).

165 *See* Bender, *supra* note 142, at 38 n.109.

cause the wealthy can afford to spend a greater percentage of their income on elective treatment. Such vertical inequity seems contrary to the deduction's purpose—to reflect a taxpayer's ability to pay.

Besides the current floor, there is the issue of a deduction that has no limit. Congress eliminated the historical cap on § 213 in part to reflect the rising costs of health care. But, in the context of infertility, the drawbacks of encouraging infinite fertility treatment must be considered when assessing the deduction. Unlimited use of ART risks the physical and emotional well being of infertile women.¹⁶⁶ The likelihood of costly and dangerous multiple births also increases with the use of ART.¹⁶⁷ An unlimited subsidy for fertility treatment seems contrary to an expenditure which aims to alléviat taxpayer burdens, not to aggravate them.

It is firmly established that § 213 will be used to deduct medical expenses for fertility treatment. Yet the unique nature of fertility technology supports certain oversight of the amount of money a taxpayer should deduct for these expenses. Ultimately, we may look to judicial interpretation of the deduction itself for the answer. The judiciary has interpreted § 213 as a way to alleviate the burden for *functionally adequate treatment* of a disease or illness,¹⁶⁸ rather than as a blank check for unlimited elective treatment.

As such, taxpayers who intend to use the deduction for fertility treatment should do so with written consent from a physician.¹⁶⁹ The physician must use his or her best medical judgment to determine what level of treatment constitutes functional adequacy, and this will vary given the circumstances of the patient. For instance, a physician may consent to a deduction for more rounds of ART for a young, healthy female than for a woman past her childbearing years. The physician would determine the line between functionally adequate fertility and where such procedures become purely optional or even experimental. Such a distinction does not prohibit any infertile couple from purchasing as much fertility treatment as they choose, but it may address the problems of an unlimited federal subsidy for treatment that carries risks of harm along with the chance for good.

Additionally, if § 213 is intended to reflect a taxpayer's ability to pay, then the floor that acts as a gatekeeper to deny access to low

166 See *supra* notes 156–59 and accompanying text.

167 See *supra* notes 149–54 and accompanying text.

168 See *Ferris v. Comm'r*, 582 F.2d 1112, 1116–18 (7th Cir. 1978).

169 Currently, taxpayers must qualify such expenses as medical only if the IRS conducts an audit on the taxpayer. Ordinarily, taxpayers do not have the burden of justifying medical expenses in order to take the deduction. See INTERNAL REVENUE SERV., *supra* note 118, at 19.

income taxpayers must be reduced. While fertility treatment remains costly and insurance coverage appears unlikely in the near future, some solace for couples that wish to undergo expensive treatment exists under the medical expense deduction. However, low income couples may find a 7.5% barrier too high to take advantage of its assistance. As such, this barrier should be lowered to increase access to the deduction for couples otherwise unable to benefit from the current deduction. Lowering the floor would open the use of the deduction for a greater number of taxpayers struck by the medical catastrophe of infertility.

CONCLUSION

Infertility is a prevalent and growing problem in this country.¹⁷⁰ While infertile couples have an ever-increasing number of treatment options to choose from,¹⁷¹ most insurance companies have refused to cover such medical expenses.¹⁷² As a result, couples pay for the expensive procedures largely out of pocket.¹⁷³ The taxpayer may alleviate the burden of costly fertility treatment by using the medical expense deduction of I.R.C. § 213. The current state of the law suggests that a taxpayer may claim unlimited expenses for fertility technology, but only if the taxpayer can afford to spend over 7.5% percent of his or her income on such treatment.¹⁷⁴ Problems arise when using the deduction as a blank check to compensate taxpayers for their elective procedures; the deduction should be capped at a level consistent with a physician's assessment of medical adequacy. Yet the purpose behind the deduction has always been to compensate taxpayers encountering unforeseen medical expenses. The floor of the deduction should be lowered to increase equality in tax benefits across all income classes, and such lowering follows the deduction's legislative history.

Ideally, these two suggestions reconcile the unique implications of using I.R.C. § 213 to subsidize assisted reproductive technology. While infertility remains an oppressive barrier to the dreams of many Americans, our nation's tax policies must be subject to consistent evaluation to ensure that they address the needs of all people in the healthiest possible manner.

170 See *supra* note 1.

171 See *supra* notes 22-23 and accompanying text.

172 See *supra* Part II.A.

173 Yamamoto & Moore, *supra* note 32, at 104.

174 See West, *supra* note 164, at 289.